

# CADUCEUS

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for the health sciences*



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*Fig. 1. The Tompkins Wheeled Stretcher model was built circa 1865 to illustrate the operating features of the design and is probably a duplicate of the patent model. The model is 25" long and the scale is approximately 4" to the foot. (Accession 703,924. Photo courtesy of Armed Forces Institute of Pathology.)*

# *Transportation of the Wounded: The Models of The Armed Forces Medical Museum*

*by Alan Hawk*

The Armed Forces Medical Museum has in its collection nine models which represent the evolution of medical transportation during the second half of the nineteenth century. These models are significant not only for their craftsmanship but also as three-dimensional documents of the technology developed or adapted to transport wounded soldiers from battlefield to hospital. Their value is enhanced further by the scarcity of actual ambulances, hospital trains and hospital ships from the period. The Smithsonian Institution collection includes only three ambulances, all dating from the Spanish American War. Very few examples of period rolling stock survive, and of those that do survive, none are configured to carry the wounded. None of the hospital ships were preserved. The only sources of information on medical transportation are drawings, documents, personal accounts and the models themselves.

Unlike drawings or written accounts, a model is a three-dimensional representation of the object. It is possible to understand functional and spatial relationships of the different components of the prototype. With the appropriate documentation, drawings (which provide details on construction) and primary sources (which provide details of the object's use) it is possible to understand the technological solutions to the problem of safely transporting a wounded soldier. In other words, a model is a document useful in the study of the history of technology.

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The opinions or assertions contained herein are the private views of the author and are not to be construed as being official or as reflecting the views of the Department of the Army or the Department of Defense.



The first mention of transportation models appears in a memorandum written in September of 1865 by Lieutenant Colonel George A. Otis, Curator of the Army Medical Museum, in which he justified the purchase of six display cases, one of which was "...for models of ambulances, stretchers, patterns of knapsacks, field companions etc. etc. etc. authorized by the Medical Department."<sup>1</sup> The catalog of the Army Medical Museum, published a year later, listed a total of eleven models in the museum collection: six models of litters, four ambulance models and one wheeled stretcher model.<sup>2</sup>

In 1875 the Army Medical Department planned its participation in the International Centennial Exposition in Philadelphia and appointed Lieutenant Colonel James J. Woodward, Curator of Medical and Microscopical Sections of the Army Medical Museum, to organize the exhibit. A replica of a post hospital was constructed to house the exhibit, which featured a hospital ward, medical equipment, models of Civil War hospitals and seven transportation models. These models, which included five railroad cars and two hospital ships, were constructed specifically to illustrate developments in rail and waterborne transportation of the wounded during the Civil War and thereafter. Although most of the designs depicted by the models date from the Civil War, they represented the most advanced configurations since, in a time of peace, there was neither the need nor the money to continue development. Full-sized ambulances were displayed in a shed behind the pavilion, and none of the ambulance models included in the museum's collection were displayed the exposition.<sup>3</sup> Woodward's exhibit received a "Certificate of Award" from the International Centennial Commission.

After the exposition, the Army Medical Museum continued to commission models illustrating advances in medical transportation until around the turn of the century. According to an inventory about 1890, the collection contained twenty-one models, including eight ambulances, seven travois, five stretchers and one wheeled litter. The seven models built specifically for the International Centennial Exposition were not listed in this inventory. These models, along with pathological specimens, represented the museum and the Medical Department at major international expositions--including the New Orleans International Exposition in 1884, the Columbian Exposition in 1892 and the Trans Mississippi and International Exposition in 1898, as well as at a number of state and county fairs.

There are two possible reasons for model construction, either as patterns for proposed designs or as documents of existing designs. A majority of the models in the collection were intended to function as documents rather than as patterns, since the models were often constructed after the prototypes they depicted. For



example, Medical Department staff built two ship models for the 1875 exposition to illustrate the best configurations for hospital ships developed during the Civil War.

The Army also considered models to be an essential part of the research and development process. For example, the Adjunct General's Office appointed a commission in April of 1875 to consider an improved design for an ambulance for the Army. In the course of the investigation, the commission examined a wide range of reports, drawings and models in order to determine the most useful configuration for the ambulance. Once the board had settled on the design, it recommended that the "Ordinance Department should be instructed to prepare three models of ambulance wagons in accordance with specifications prepared by the board, on a scale of three inches to the foot...", followed by four or six full-sized ambulances to be built for field tests.<sup>4</sup>

In 1936 the Army Medical Museum loaned twenty of the models to Carlisle Barracks in Pennsylvania, for display in a museum run by the Medical Field Service School. Due to the research demands placed upon Army Medical Museum staff, which had outgrown its building by World War II, the museum's collections had to be placed in storage, and no attempt was made to reclaim the models. When the Medical Field Service School moved to Fort Sam Houston in 1946, the models were moved along with the rest of the equipment. It was not until 1968, when the new museum wing was being built, that the Armed Forces Medical Museum, formerly the Army Medical Museum, contacted the museum of the Medical Field Service School, now the Army Medical Corps Museum, for the return of the models. After extensive negotiation, the nine models discussed here were returned in May, 1968. The remainder were kept by the Army Medical Corps Museum.

One of the first models acquired was that of a wheeled stretcher (Fig. 1), designed by General Charles H. Tompkins and patented on August 7, 1866. The model was listed in the 1866 catalog with the following notation: "This has been recommended for adoption in 1865."<sup>5</sup> The design was ultimately not adopted, and there is no evidence that a full-scale prototype was ever built.

Constructed of oak and cloth with steel hinges and fittings, this model appears to be a duplicate of the patent model, which was designed to demonstrate the unique functions of the object. The model features foldable legs, an adjustable backrest and detachable wheels. To protect the patient from the elements, a blanket could be unrolled from a spool at the foot of the stretcher and a collapsible hood could be raised over his head. The purpose of this design, according to a copy of the patent awarded on August 7, 1866, was "to so construct a stretcher that it can be adjusted and adapted to afford support on greatest possible comfort, to



*Fig. 2. This model of a four-wheel ambulance, roughly similar in proportion to the Wheeling Ambulance, was built circa 1863-1864. The body of this model is approximately 20" long. (Accession 704,166. Photo courtesy of Armed Forces Institute of Pathology.)*

wounded limbs or other parts of the body. At the same time provision is made for folding the several parts of the stretcher into a very compact space...." The stretcher could be carried or mounted on wheels.<sup>6</sup> The model documents how far the concern for the comfort of a wounded soldier had evolved from the 1861 Coolidge ambulance, which did not have a suspension system, to this 1865 stretcher with detachable wheels on elliptical springs, which could be adjusted to provide the most comfortable position for the patient.

In 1859 the Army recognized the need for a specialized design for an ambulance rather than continue to rely on transport wagons to remove the wounded from the battlefield. The result was a wide variety of configurations, ranging from two-wheeled ambulances, which were unpleasant for a wounded soldier to ride in due to the rocking motion while underway, to a heavy and cumbersome wagon drawn by four horses that could carry six seated men and four in stretchers. As a result of wartime experience, the Army settled on a four-wheeled, medium-sized ambulance drawn by two horses. This ambulance could carry two men in stretchers or up to ten seated passengers. Because patient comfort was a major consideration, many suspension systems were considered.

There is very little solid documentation on the first ambulance model (Fig. 2). None of the descriptions of the model identify what type of ambulance it was to represent, and it first appears in the 1866 catalog as a "model of the ordinary four-wheeled ambulance in general use during the rebellion."<sup>7</sup> The model itself provides some information. A metal plate on the rear door identifies the builder as J. A. Conover of 130 Horatian St., New York, who was listed in the 1863 city directory as a woodworker. On the sides of the body is the notation "inspected by J. S. Dunlap." *The Historical Register and Dictionary of the United States Army* lists Lieutenant Colonel James Dunlap as having served in the Quartermaster's Department, which was responsible for procurement of ambulances, from January to August, 1863. Dunlap, who had previously served as a captain in the Quartermaster's Department of the Kentucky Volunteers, resigned on June 11, 1864. If this is the same J. S. Dunlap, then the model would date from 1863 to 1864.

Of the transportation models in the collection, this one is the least detailed. Only the general configuration, a four-wheeled, two-horse ambulance similar to the Wheeling Ambulance with the capacity for two men on stretchers, is documented. Unlike the other ambulance models, only the most general attempt was made to represent the construction of an actual ambulance. The body was made of quarter-inch-thick wood connected by dovetail joints, with the "framing members" painted on the body. No braking system is depicted. While the front wheels do steer, the axle pivots on a nut and bolt rather than on a fifth wheel. The only

other operating features are the tailgate and a bench seat that folds out to form a bed to receive the stretcher. Unlike most ambulances of the period, in which the bench is created by folding down the leaf of the bed, the leaf of this model folds up, doubling over to form the seat of the bench. When the bed is folded out, it is supported by three center posts, which appear to have been added recently. Unfortunately, a well-intended but ill-conceived restoration attempt in 1968 altered the model, making it difficult to determine the original design of the builder.<sup>8</sup> It appears that this model was intended not to document an ambulance type but to serve as a patent model to illustrate a specific feature of an ambulance--in this case, the tailgate served as the folding bench.

If the model actually was intended to illustrate the arrangement for loading and carrying the patients, who designed this configuration and why was the model built? In 1863 New Yorker Augustus W. Sus patented an ambulance which could carry four patients on stretchers. The benches could be folded flat on the floor and a backrest put down to create a second tier. The Army convened a committee, which included Major John H. Brinton, the first curator of the Army Medical Museum, to evaluate the design. While this group did not choose to recommend the ambulance, it did conclude that it might be desirable to modify the Wheeling Ambulance design according to the Sus design. In 1864 Sus offered another version, which was described by Assistant Surgeon W. E. Walters, who inspected the proposal:

These improvements consist in adapting the ambulance for the conveyance of four patients lying down, instead of two, as with the present arrangement, while, at the same time, the carrying capacity for such as can sit up is not at all interfered with. The improvement is effected by having seats fastened with hooks to the side of the ambulance so that they can be detached and put on the floor, thus forming a bed, on which the patient can lie with full as much comfort, as regards position, as with the present arrangement, while they are made more comfortable by the addition of elastic springs within the cushion.<sup>9</sup>

It is possible that this model was built to demonstrate the concept to the Board, since there are so many similarities with circumstances of the Sus design. This model, built in New York, illustrates the features similar to those covered by the patent. However, a careful inspection of the model raises more questions than it answers. Why does the configuration of folding bench not match any of the known documentation? Why is there no evidence of a second tier as indicated in the patent? If the model was not built to illustrate Sus' design, why was it built? How much has the model been changed from its original configuration?





*Fig. 3. The Rucker Ambulance model, built in 1866, features removable stretchers and an operational brake system. The body of this model, built on a scale of 3" per foot is approximately 31" long. The photograph shows the two-tiered arrangement of the stretchers. (Accession 704,563. Photo courtesy of Armed Forces Institute of Pathology.)*



*Fig. 4. The model of the Improved Army Ambulance, 1900 pattern, built in 1901 by the Terre Haute Carriage and Buggy Company, is a 1/4 scale duplicate of the prototype down to the construction details and material. The body of the model is 31" long. (Accession 704,994. Photo courtesy of Armed Forces Institute of Pathology.)*



Developed in 1865, the Rucker Ambulance (Fig. 3) was described by Otis in the *Medical and Surgical History of the War of the Rebellion* as the “most serviceable ambulance used in the latter part of the war...”<sup>10</sup> This model was built in 1866 at the U. S. Army Repair Shops of the Lincoln Depot in Washington, DC. Constructed of oak with steel fittings, it faithfully duplicates the construction of the prototype and features an operating mechanical brake, movable louvers on the sides of the body, and an opening tailgate. The ambulance could carry four patients on two levels of specially designed stretchers, a feature that was patented on November 6, 1866.<sup>11</sup> The inside half of the mattress on the lower level could be folded downward to create a bench set. The upper level mattress could be lowered to rest along the sides in order to create a backrest. A significant feature of this type of ambulance is the suspension system, in which the axle is mounted on two semi-elliptical leaf springs attached to a transverse semi-elliptical spring. Further evidence of the intent to reduce jarring the patient is the leaf spring attached to the whippletrees, which are attached to the harnesses of the horses.

Was this model a duplicate of a patent model? Built the same year of the patent, this model reproduces the hardware for mounting the stretchers described by the patent. It is considerably more detailed, however, and features mechanisms, such as the brake and suspension systems, not included in the patent. The fact that the model was built at an Army depot suggests that it was not a patent model but rather a pattern model created to document the design.

The third ambulance model (Fig. 4) is of the Improved Army Ambulance, 1900 pattern, which was adopted by the Army on August 18, 1899. The Surgeon General authorized two hundred dollars for the construction of the model in January of 1901. Because authenticity was the paramount consideration, the model was to be built of the same materials as the prototype and its construction supervised by the quartermaster's staff. As Colonel Alfred A. Woodhull wrote to the Surgeon General, “if the model is built by the same parties who built the wagons, it is more reasonable to suppose that it will be accurate.”<sup>12</sup> The scale of the model was to be 3 inches to the foot, the same scale as the other ambulance models.

The Terre Haute Carriage and Buggy Company was awarded the contract to build the model. At first, the company wanted to change the specifications, as is apparent in this correspondence from company spokesman A. M. Higgins to Captain Joseph Z. Dare, the Assistant Quartermaster General:

We wish to know whether you desire the model to be constructed throughout of the same material as the regular ambulance or whether

you would permit us to construct it of such materials as can be more properly used in the construction of a model of that size and yet have the same appearance and at the same time supply the place of the original. It is impossible to construct a model of that character of the same material throughout as called for in the specifications for a price less than \$250,000 as there are so many small parts of the ambulance which would be exceedingly difficult to supply in the material specified except at a much greater cost of labor than the regulation size would cost.... We have found that the following one-fourth size is inconvenient and would ask if it would not be more practical for us to build the model one-third size or four inches to the foot. We are constructing the No. 1 U.S. Screen Mail Wagon for the Post Office Department on that scale and find it the best scale possible.<sup>13</sup>

Both proposals were rejected and Higgins had to back down, promising that the model would be "...complete in every detail, not only a perfect reproduction of the regular ambulance in appearance, but in particulars throughout..."<sup>14</sup>

Completed in July of 1901, this model is proof that the basic configuration developed by Sus was considered valid forty years after it was designed. Both designs shared the same suspension system. Like the Rucker ambulance, the 1900 pattern could carry four patients on two tiers of stretchers or could carry seated passengers on bench seats.<sup>15</sup> The main difference is that the later design used standardized stretchers made of cloth with wood poles, while the Rucker model had contained two different types of stretchers built specifically for the ambulance, for each wooden tier and its companion padded mattress. Instead of folding the lower stretcher as with the Rucker Ambulance, the 1900 ambulance features benches attached to the body which fold down to provide space for the lower stretchers.

When the Civil War broke out in 1861, America's expanding railroad system was appropriated for the war effort to transport men, supplies and munitions to the front and the wounded to the hospitals in the north. The railroads were the most efficient means of sending the wounded to the rear for treatment. In the *Medical and Surgical History of the War of the Rebellion*, Otis wrote:

After the Battle of Gettysburg in July 1863, 20,342 wounded came under the care of the medical officers of the Army of the Potomac and in two weeks, 15,425 has been forwarded to Baltimore, York, Harrisburg and New York City. Of the remainder a large portion was unable to bear the protracted journey. After the bloody battles of the Wilderness and Spotsylvania, the distribution of the wounded was even more rapidly affected and the fallen were within a few days comfortably shel-



*Fig. 5. The model of the hospital car of the Army of the Cumberland was built for the Centennial Exposition to document one of the more effective means of converting a passenger railcar to accommodate wounded soldiers. The model is approximately 49" long. The photograph of the top view of the model shows arrangements of the bunks. Note the elaborate ceiling painting and lanterns. (Accession 704,095. Photo courtesy of Armed Forces Institute of Pathology.)*



*Fig. 6. This model of a boxcar was built for the Centennial Exposition to illustrate a proposal for adapting an ordinary freight car into a hospital car. The length of the model is 31." (Accession 704,095. Photo courtesy of Armed Forces Institute of Pathology.)*



tered in the hospitals at Alexandria, Washington, Baltimore, Philadelphia and New York.<sup>16</sup>

According to Otis, the advantage of the hospital train was that it allowed for the creation of large centralized hospitals away from the battlefield. This situation freed soldiers from having to care for their wounded comrades. Located in large cities, hospitals had easier access to supplies and so could provide better care for wounded soldiers than a field hospital close to the front. There was one problem, however. At a time when long-distance travel by rail was uncommon, not many passenger cars were designed to accommodate sleeping passengers. War surgeons on the front had to adapt existing rolling stock, both passenger and freight cars, to carry the wounded. Since no standard pattern was developed by the Army at the beginning of the war, the surgeons, left to their own devices, came up with many different designs.

To illustrate the more promising configurations, five models of railroad cars were constructed to be exhibited at the 1875 exposition. Three of the models documented passenger cars adapted by the Army of the Cumberland, one was of a hospital care used by the Army of the Potomac and the fifth represented a postwar proposal for using freight cars. Two of the models, a hospital car of the Army of the Cumberland and the freight car, are included in the museum collections.

The models were constructed in 1875 by J. G. Brille and Company of Philadelphia, a firm that manufactured railroad cars. This company did not get into the business of making railcars until after the Civil War. Both models are exquisite in their detail. Constructed of hardwood with brass fittings, these models, which faithfully duplicate the construction of prototype, feature detailed couplers and undercarriage as well as an operating mechanical brake system. In addition to their significance relating to the transportation of the wounded, they are also useful for the study of period rolling stock technology.

The hospital car of the Army of the Cumberland (Fig. 5) shows the best arrangement for modifying a passenger car to carry wounded soldiers. Alternate seats were removed as were the seat backs. Boards were laid on the benches, which were then covered with a mattress. A second tier was created by suspending stretchers from an iron hook mounted in the ceiling. Each car contained a water closet and a wood stove. Ventilation was provided by clerestory windows. The model illustrates a simple and straightforward adaptation of a passenger car to a hospital car, using easily available material.

The freight car (Fig. 6) illustrates a plan developed by the Prussian Commission of 1868.<sup>17</sup> Ordinary field stretchers were supported by wooded rails mounted on elliptical springs. This model is unusual in that rather than documenting existing technology, it was intended to propose a new method for adapting rolling stock to transport the wounded. In the brochure describing the exhibit, Woodward wrote:

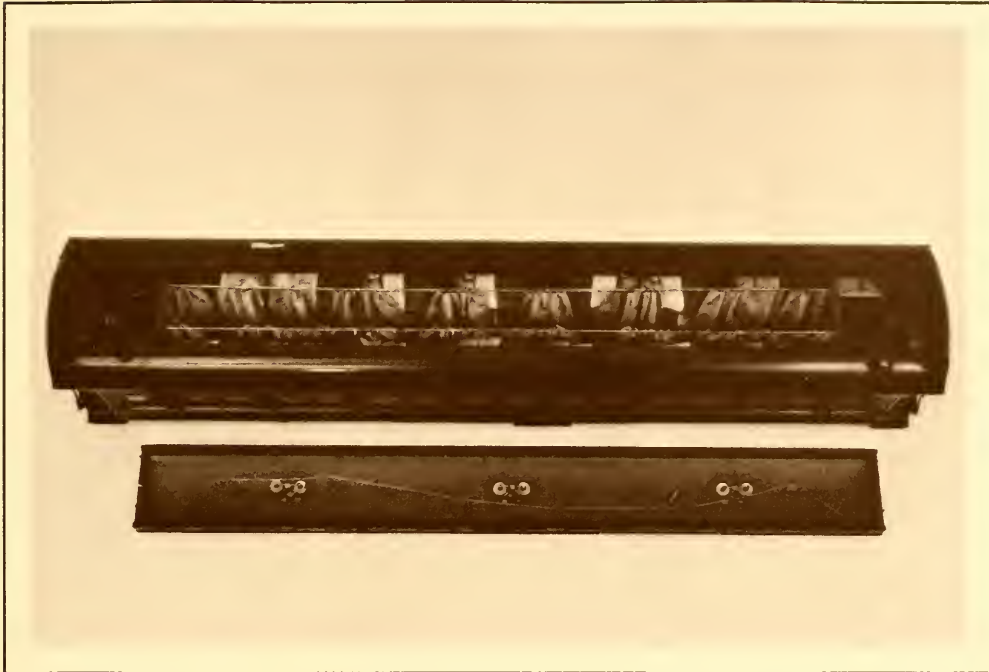
Assistant-Surgeon Otis has recommended that, in any future war, the Quartermaster's Department of our army should be authorized to keep on hand a supply of these semi-elliptical springs. Trains going to the front with provisions, forage, or ammunition, should each carry suspended under the roof, a sufficient number of these springs, with the spikes required, to enable the car on its return, instead of going back empty, to carry comfortably, on beds improvised by means of ordinary field stretchers, a number of sick or wounded, corresponding to its size. Assistant-Surgeon Otis has also suggested that these springs might be utilized in connection with field stretchers for the comfortable conveyance of the wounded in ordinary army wagons.<sup>18</sup>

When the United States went to war with Spain in 1898, Medical Department staff chartered a number of passenger cars to transport wounded soldiers from hospital ships in southern ports to the hospitals. Unlike the Civil War hospital cars, which consisted of extensively modified passenger or freight cars, these cars were standard "tourist sleeping cars" leased from the Pullman Palace Car Company (Fig. 7). According to Major Charles Richard, commander of a hospital train during the war, a train consisted of 10 hospital cars containing 28 berths, a combination baggage car, office and dispensary, a dining car and a private car for use by the officers of the train.<sup>19</sup>

In 1901, after contacting Richard for any information and drawings of the hospital cars, the Army Medical Museum ordered a model of a tourist sleeper car from the Pullman Palace Car Company. The instructions accompanying the order included the following stipulation: "In making the model, it would not be necessary that it be made throughout of the same materials as the car itself, but the general appearance and details of construction should be preserved. The roof of the car should be readily lifted off, to show the interior." The specifications listed cars 2571, 2587, 2589, and 2593 as being among the cars used in the hospital train.<sup>20</sup>

This model, which was delivered to the museum on June 28, 1901, had some minor discrepancies compared to the prototype described by Richard. The serial number on the model, 1001, was not one of the serial numbers of the cars used on the actual train. No curtains were used to close off the bunks, since they





*Fig. 7. In 1901 the Pullman Palace Car Co. was commissioned by the Army Medical Museum to build this model of a Tourist Sleeper Car, which had been used during the Spanish American War for transporting wounded soldiers. The length of this model is 60." (Accession 705,278. Photo courtesy of Armed Forces Institute of Pathology.)*

would have interfered with the care of the patient. However, the model features curtains, which were standard on civilian Pullmans, since Woodhull never indicated to the contractor that they should be omitted. Despite these minor inaccuracies, the model documents that a civilian sleeper car, without any changes, could be and were used by the Army to transport the wounded.

One significant detail illustrated by these models is that, unlike the horse drawn ambulances, no elaborate suspension system was developed for the patients. Neither the Army of the Cumberland hospital car, with its patients riding on pallets mounted on benches or in stretchers suspended from the ceiling by rigid iron hooks, nor the Pullman Sleeper car, with the bunks rigidly mounted to the bay partitions, isolated the patients from the swaying and jolts of railroad travel. The suspension system on the trucks of the passenger cars were considered sufficient. Only the freight car, with its less sophisticated suspension, provided springs to soften the ride.

All the railroad models in the collection illustrate the evolution of the hospital train during the second half of the nineteenth century. Prior to the Civil War, the Army did not develop specialized hospital train cars since there was no reason to do so. The unprecedented carnage of modern warfare made it clear that an improved method of evacuation was necessary, however, and railcars--as illustrated by the Army of the Cumberland hospital car--were adapted to accomplish the task. The freight car model documents that this approach, rather than creating a specialized hospital car, was considered by the Army to be the best solution to the problem a decade after the war. The completion of the transcontinental railroad in 1869, the subsequent increase in long-distance rail travel, and the popularization of the sleeper car made the problem moot. There was now an existing railcar--as illustrated by the model of the Pullman Sleeper car--that could be used as a hospital car with minimal modification.

The two hospital ship models were built for display in the Army Medical Department Pavilion at the Philadelphia exposition. Woodward describes the ship models thusly:

These models are intended to illustrate the plans actually employed during the war of 1861-5 for adapting the ordinary steamboats of the interior rivers of the United States and the merchant steam vessels of the Atlantic coast, to the transportation of sick and wounded soldiers....It was, of course, on the Mississippi River and its tributaries, in the rear of the great western armies, that methods of fitting up riverboats were brought to the greatest perfection. The military operations in the Mississippi valley, during the greater part of the war, were so related to these streams that they offered the most convenient and



*Fig. 8. This model of the D. A. January was built for the Centennial Exposition to illustrate a Civil War era inland waterway hospital ship. Panels on the walls of the superstructure fold upward to allow the interior details to be visible. The model is 60" long. (Accession 703,903. Photo courtesy of Armed Forces Institute of Pathology.)*



*Fig. 9. The cross-section model of the J. K. Barnes, the side showing the interior details depicted here, was built for the Centennial Exposition to illustrate the configuration of a coastal hospital ship. The model is 96" long. (Accession 704,179. Photo courtesy of Armed Forces Institute of Pathology.)*

economical routes of transportation and the numerous large river steamboats, which in times of peace are occupied in transporting merchandise and passengers, required little alteration to convert them into commodious hospital boats well suited to the transportation of the sick and wounded.<sup>21</sup>

The two ship models, the *D. A. January*, an example of a hospital riverboat, and the *J. K. Barnes*, an example of a coastal hospital ship, were built under the supervision of Assistant Surgeon Alfred H. Hoff of the Army Medical Board in New York City.<sup>22</sup> Hoff had firsthand knowledge of both ships, since he served as Surgeon-in-Charge of the *D. A. January* and directed the refitting of the *J. K. Barnes* into a hospital ship. The model of the *J. K. Barnes* was built by Charles Hemje, a New York nautical architect, who did the design work for the actual ship. Although the builder of the *D. A. January* model has not been identified, it was probably built by Hemje, based on similarity of workmanship and the fact that Hoff was in charge of getting both models built.

The significance of these models is their interior detail illustrating the configuration of the hospital wards. "My own idea, in a general way," wrote Woodward to Hoff, "is that the models should be sections showing the interior arrangements of bed s, etc...."<sup>23</sup> Only the *J. K. Barnes* was completed as a cross section model. The *D. A. January* is a full-width model, its interior detail easily visible through hinged panels on the superstructure walls.

*The D. A. January* (Fig. 8) was built in 1856. In the Spring of 1862, she became the first riverboat purchased, rather than leased, by the Army for use as a hospital ship. To accommodate the hospital ward, the staterooms on the cabin deck were illuminated and the veranda was enclosed. There were facilities for 400 patients, a surgical ward and pharmacy. The model reproduces the interior details down to the individual beds, the tables in the mess area and the railing at the stairwells. The most notable discrepancy between the model and the available documentation is that a floor plan illustrates three rooms, a surgical ward, a pharmacy and the linen storage, to the rear of the cabin deck while the model doesn't have those rooms.

*The J. K. Barnes* (Fig. 9) was fitted as a hospital ship in 1864 to convey the wounded from field hospitals in the South to hospitals in Alexandria, Philadelphia and New York City. The ship had a length of 223 feet and could carry up to 449 patients. Again, this model accurately documents the internal configuration of the ship with the exception of the engine room. The model depicts a tightly packed hospital ward inside the hull with permanent three-tiered bunks that are



securely mounted to the deck. Also shown is the location of the radiators, wash basins and the latrine, complete with bath tub split down the middle.

These two models illustrate how ships were adapted to carry the wounded in different conditions and for different functions. While the *J. K. Barnes* was primarily a transport, the *D. A. January* was a floating hospital. The *J. K. Barnes* had only facilities for the care of patients in transit; there was no pharmacy or surgical ward, since a ship on the heaving seas of the North Atlantic would not have been the best place to perform an operation. The patients to be shipped would had to have been in stable condition due to the facilities, the poor ventilation inherent in the design, the densely packed wards and the rigors of the voyage, a fact illustrated by the loss of only 25 of the 3,655 patients transported northward in 1865.

On the other hand, in addition to the patient wards, the *D. A. January* had a surgical ward and a pharmacy. In contrast to the bunks in the *J. K. Barnes*, the *D. A. January* equipment included used standard hospital beds, a condition which allowed for greater comfort and easier access to patients. Better ventilation was due to the large windows on the superstructure, a feature not possible on the *J. K. Barnes*. Since the *D. A. January* operated on the calm inland waterways, it was possible to provide a full range of medical care, which compared favorably with the land-based hospitals of the day.

The models in the collection of the Army Medical Museum document the evolution of medical transportation of the second half of the nineteenth century, a period when the need for specialized means for transporting the wounded were being recognized and developed. From the study of these models, it is possible to understand the technology that was created to solve the unique problems of transporting a wounded man comfortably and safely. However, the question arises of why a model should be considered a document worthy of study as opposed to the drawings, specifications, historical accounts or photographs. While these documents are invaluable to understanding artifacts, they are limited in that they are only two-dimensional representations of a three-dimensional object.

Historically, models have been considered valuable in understanding technology, especially from the developmental point of view. In the sixteenth and seventeenth centuries, the British Admiralty evaluated proposed warship designs by using models illustrating the configuration of the hull and construction details. Throughout the nineteenth century, United States Patent Office regulations required models illustrating mechanisms to be patented to be included in the patent application. The agency rescinded this regulation finally when it had no



more storage space to house the models. More recently, chemical processing plants have been designed through the initial use of models before drawings are made since it is virtually impossible to determine the correct layout of pipes on paper. Models offer an inexpensive means of illustrating and testing a concept without building of a full-scale prototype.

Another advantage of a model is that technology is brought down to a more manageable scale. While it can be difficult to examine and comprehend a large object such as a ship or a railcar, a model of the same object, by the very nature of its size, can be studied more easily and the spatial relationships of the different components can be understood more easily. It is this feature that makes the model useful for public displays since it can illustrate the features of the object dramatically and clearly. Unlike either the full-scale object or a drawing of the object, a model does not depend on the spatial thinking ability of the viewer to be understood.





1. *Letter Book No. 1, Department of Surgical Records, Surgeon General's Office*. Otis Historical Archives, Armed Forces Medical Museum, 169.

2. Alfred A. Woodhull, *Catalog of the Surgical Section of the United States Army Medical Museum* (Washington, D.C.: US Government Printing Office, 1866), 79.

3. A list titled "Articles listed at Centennial Exposition, 1876," and dated October 28, 1885, lists the ambulance and stretcher models as being displayed at the exposition (see Otis Historical Archives.) However, brochures printed for exposition and photographs of the display indicate that these models were not included. (see Joseph J. Woodward, *International Exhibition of 1876, Hospital of the Medical Department, United States Army* (Philadelphia: 1876.)

4. "Preliminary Report of a Board of Officers Convened by Special Orders No. 44, War Department, Adjunct General's Office, March 16, 1875," Otis Historical Archives.

5. Woodhull, *Catalog*, 79.

6. See United States Patent Office, Patent 57,013.

7. Woodhull, *Catalog*, 79.

8. In addition to the center posts, new pieces to the model include the right side bed, the left side barrel under the bed, the hinges to join the bed/bench halves and a vinyl cover. The model has been repainted.

9. George A. Otis and David L. Huntington, *The Medical and Surgical History of the War of the Rebellion, Part III, Volume II, Surgical History* (Washington: Government Printing Office, 1883), 951.

10. *Ibid.*, 952.

11. See United States Patent Office, Patent 59,459.
12. Letter from Colonel Alfred A. Woodhull, Director, Army Medical Museum, to Brigadier General George M. Sternberg, Surgeon General, January 21, 1901. (Otis Historical Archives, Accession Record 704,994).
13. Letter from A. M. Higgins, Terre Haute Carriage and Baggage Co., to Captain Joseph Z. Dare, Assistant Quartermaster General, February 2, 1901. Accession Record 704,994 (Otis Historical Archives, Accession Record 704,994).
14. Letter from A. M. Higgins, Terre Haute Carriage and Baggage Co., to Major Joseph Z. Dare, Assistant Quartermaster General, March 11, 1901. (Otis Historical Archives, Accession Record 704,994).
15. The ambulance adopted in 1875 dispensed with the second tier of stretchers.
16. Otis and Huntington, *Medical and Surgical History*, 957.
17. This was the commission appointed by the Prussian Army in 1868 to study means of evacuating wounded soldiers from the battlefield.
18. Woodward, "Description of the Models of Hospital Cars Exhibited in Room No. 2," *International Exhibition of 1876*, 10.
19. Letter from Major Charles Richard, Surgeon, U.S. Army, Fort Leavenworth, Kansas, to Colonel Alfred Woodhull, Director, Army Medical Museum, 31 January 1901. (Otis Historical Archives, Accession Record 705,278).
20. Letter From Colonel Alfred A. Woodhull, Director, Army Medical Museum, to C. A. Garcelor, General Superintendent, Pullman Palace Car Co., 21 February 1901. (Otis Historical Archives, Accession Record 705,278).
21. Woodward, "Description of Hospital Steam Vessels in Room No. 2," *International Exhibition of 1876*, 3.
22. The *J. K. Barnes* was named in honor of General Joseph J. Barnes, the Surgeon General for the U. S. Army from 1864 to 1882. The source of the name *D. A. January*, which predates the ship's army service, is unknown.
23. *Letter Book 1875, Laboratory and Museum, Vol. 9, Surgeon General's Office*, Otis Historical Archives:57.



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Fig. 1. Display of reconstructed doctor's office, Cleveland Health Museum, 1943. Howard Dittrick called this the "office of Dr. Abner Webb" and presented it as such to the public. However, none of the furniture and few of the medical instruments actually belonged to Webb. The office desk, for example, was originally owned by an anatomy professor at Western Reserve, while the elaborate, cased Cammann stethoscope of ivory and silver bears an 1868 presentation plaque of the Bellevue Hospital Medical College in New York City. These are probably not the sort of furnishings visitors would have encountered in Dr. Webb's small town practice. Even if these substitutions are accepted, other problems of artifact provenance and appropriateness arise. For instance, the examining chair (next to the desk) and examining table (in the right foreground) both date from the mid to late 1880s, a decade or more after Webb's death (1874). Another troubling item is the large Lister spray apparatus on the very top of the desk. This particular one was acquired in 1882 and brought back to Cleveland by Dr. Dudley Peter Allen, who became Professor of Surgery at Western Reserve and who, incidentally, conceived of and actually started the historical museum of the Cleveland Medical Library Association. Sprayers such as this are more remarkable for their rarity than their ubiquity; this apparatus definitely does not belong in the office of Webb.



# *The Medical Period Room*

by James Edmonson

## I

The restored or recreated doctor's office is perhaps the most widespread and popular form of medical history exhibit in use today. This mode of interpreting the past appears prominently in state and local history museums, in specialized museums devoted to medical history and in national museums of the history of science, technology and medicine. Despite the ubiquity of the medical period room, and specifically of the doctor's office,<sup>1</sup> this vehicle for presenting and interpreting the history of medical practice has received remarkably little scrutiny. For example, a question seldom posed, much less answered, is: Do such installations offer an accurate view of the medical past? There is little discussion of this fundamental question in the literature pertinent to either medical history or medical museums. Addressing this and related issues is prompted by the observation that most, if not all, re-creations of doctors' offices conjure up nostalgic images of the physician that distort any real understanding of the past.

Perhaps the most troublesome aspect of recreated doctors' offices, particularly those ostensibly dating from approximately 1850 to 1920, is that they present a homogenized, undifferentiated product. Restored or recreated offices in places as diverse as Lewes, Delaware, Lima, Ohio, or Bailey, North Carolina, present a remarkably similar rendition of the idealized general practitioner, that Rockwellian mainstay of the American medical scene prior to the extensive specialization that has characterized the profession since the last war. Recent research suggests that medical practice, particularly in the choice of therapeutic treatments, varied substantially from place to place.<sup>2</sup> Equally significant variations in medical practice separated doctors in rural settings from their counterparts in urban centers.<sup>3</sup> Seldom is this divergence suggested in most re-creations of period doctors' offices, however. Still further discrepancies occurred from one decade to the next as the pace of technical change in medicine quickened. Again, most recreated doctors' offices scarcely show evidence of acknowledging such changes.

Whether this situation is the product of certain professional ideologies or politics, or is simply a quirk common to views held by amateur historians, is unclear. Admittedly, the extent of the problem may vary from one museum to the next. Nevertheless, the outcome is usually the same--recreated doctors' offices present a static, unchanging ideal of medical practice.

Any attempt to reconsider the appropriateness of the medical period room should begin with an examination of the types of period settings found in general historical museums and, more specifically, in decorative arts museums. It was about twenty-five years ago in articles written for the periodical *Curator* that Edward P. Alexander and A. E. Parr traced the origins of the period room in America and Europe in the late nineteenth century and offered categories or definitions to describe the types of period rooms that have developed in the present century.<sup>4</sup> Alexander and Parr agreed that period rooms could be separated into two principal categories: artistic and historical. With the artistic, or aesthetic, period room, the attempt is to depict trends in fashion and taste, assembling aesthetically significant examples of the decorative arts in a single room or environment. Unfortunately, this category violates historical reality since no past group or individuals had such consistently high standards of taste. Historical accuracy as such, however, is not the goal sought with the artistic period room. Instead, the object is to create a genealogy of today's taste. Historical period rooms, in contrast, present a moment in time that captures a lived-in, representative environment. Considerable research is required to document the authenticity of a generalized lifestyle, and even more research is necessary if the period room focus (thematic, geographical, and temporal) becomes more specific.

According to historian E. McClung Fleming, this narrowing of focus in effect makes the installation of a period room the equivalent of a curatorial publication, and as such ought to be subject to critical appraisal and review.<sup>5</sup> Fleming suggested several possible categories to deal with this dilemma, each category with its own philosophy and objective. Fleming's classifications are based upon several stipulations: 1) the degree to which historical authenticity is the predominant concern (period setting vs. period room); and 2) whether the concern for authenticity relates primarily to historical, artistic, or utilitarian considerations. It is the latter of these categories that appears to accommodate the medical period room most comfortably. As explained by Fleming, the purpose of the utilitarian period room is to "offer in their functional interrelationship, a short-hand summary of a range of utensils, weapons, or merchandise appropriate to some historical operation, profession, or activity." As Fleming elaborates on the character of the utilitarian period room, it becomes apparent that most recreated or restored doctors' offices do indeed fall into the utilitarian category. He notes: "The conscious result can be a room containing more of these

utensils or tools than any historical counterpart would ever have had." While this result is not objectionable in itself, I feel that many such medical period rooms are presented implicitly as historical period rooms as well. According to Fleming, the historical period room is one that resembles as closely as possible an actual room as it once appeared. To my knowledge, true historical period rooms are few and far between in medical museums and other sites of recreated or restored doctors offices.

These observations lead back to the basic question of why recreated doctors' offices so frequently present a static and essentially ahistorical view of medical practice. Some curators dismiss this question with the disclaimer that their period settings or rooms should be considered as teaching tools and therefore should not be judged by the same criteria or standards that apply to true historic re-creations. As such, the medical period room serves a didactive function, providing the point of departure for interpreting American medicine and medical practice in very general terms. I find this kind of reasoning very disturbing. One colleague who shares this concern is Mary Ann Landis, Curator of Eckley Miners' Village (where there is a company doctor's office under restoration) of the Pennsylvania Historical and Museum Commission. Landis contends that by "knowingly creating an inaccurate medical period room, one is consciously disseminating misinformation. Is it then an effective teaching tool? In situations such as this, it would be better to create a strictly object-oriented [gallery hall] exhibit and interpret it as such. This is the basic, universal problem of interpretation and the historic interior."<sup>6</sup>

I concur fully with Landis' comments and propose that if curators persist in utilizing the period room to interpret the medical past (and I am not advocating its abandonment as such), it is essential to give the means, as well as the subject matter, most careful attention. To this end, I have traced the development or, more properly, the evolution of the medial period room at the Dittrick Museum over a span of four decades. Perhaps by understanding how medical period rooms evolve, it may be possible to identify the pitfalls.

## II

The first attempt to create a doctor's office period room or setting by Dittrick Museum staff was in 1943. That year marked the centennial anniversary of the founding of Western Reserve University School of Medicine. To celebrate the occasion, the Cleveland Health Museum placed its second floor at the disposition of Howard Dittrick, then the Director-Curator of the Museum of Historical Medicine (now the Dittrick Museum) of the Cleveland Medical Library Association. With cooperation from the Health Museum and the Western Reserve His-

torical Society, Dittrick mounted a temporary exhibition entitled "100 Years of Progress in Medicine in Cleveland." The centerpiece of Dittrick's exhibition was a re-creation of a nineteenth-century doctor's office, ostensibly that of Abner Webb, M.D. (1821-1874).

Dittrick chose Abner Webb as the persona around whom he developed the office in part because Webb was an early graduate (1846) of the Cleveland Medical College, as Western Reserve's medical school was then known. A more important stimulus lay in the 1934 donation to the museum of Abner Webb's correspondence, account books, and other manuscript evidence documenting his student days at Western Reserve and a subsequent gift in 1942 of instruments and equipment Webb acquired when beginning medical practice.<sup>7</sup> With these unique materials Dittrick might have created an intimate portrayal of student life in the first years at the Cleveland Medical College, complete with Webb's comments on his professors, clinical instruction, or diversions that students sought from the academic routine, as well as the perennial requests for money from home. An equally interesting alternative lay in recreating Webb's first years as a physician, particularly since his manuscripts document his first purchases of books, drugs, and instruments, many of which had come to the museum only a year before the observation of the Western Reserve centennial. Instead of pursuing either of these ideas, or still other options, Dittrick chose to create a full-fledged doctor's office, incorporating a hodge podge of medically related objects spanning the period from 1840 to 1890. When completed, the office setting contained far more objects than Webb's manuscripts and the accompanying artifacts indicated. In effect, high Victorian clutter had obliterated a much simpler historical reality (see Fig. 1). Nonetheless, the result was a rave success, judging from notices in the *Museum News* of the Cleveland Health Museum.<sup>8</sup> The preview opened on October 26, 1943, with Chauncey D. Leake, M.D., Dean of the Medical College at the University of Texas, presenting a talk entitled "Milestones in Medicine."<sup>9</sup> Public interest and attendance proved so great that the Cleveland Health Museum extended the exhibit two weeks, so that it lasted through the end of November, 1943.

Why did Howard Dittrick approach the period room in this way? He was a meticulous scholar whose publications documented the kinds of diagnostic instruments, medications and therapeutic techniques that early and mid-nineteenth-century Ohio physicians employed.<sup>10</sup> Interestingly, Dittrick based his works upon not only manuscript collections and newspapers, but also upon artifactual evidence. A lack of thoroughness in research and documentation cannot explain Dittrick's approach to the period room. A more plausible explanation lies in his delight in collecting and his fascination with the artifacts he acquired for the museum. When Dittrick created his period room in 1943, he employed it



chiefly as a vehicle to showcase as many objects as possible. In the process, he unfortunately succumbed to the irrepressible urge to fill the room to capacity, paying scant attention to the same standards of accuracy and authenticity that he felt applied to his written work.

The Abner Webb office was Howard Dittrick's first and last attempt to recreate a period doctor's office. From 1942 to 1960 the museum gallery on the third floor of the Allen Library (the site of the Cleveland Medical Library Association) became home to the Rare Book Collection of the Surgeon General's Library. During this period (which I have dubbed the "Babylonian Captivity"), the Dittrick Museum collections and exhibits were confined to cramped, makeshift quarters adjacent to the main museum gallery. Dittrick's own death in 1954 left a void of initiative and inspiration regarding the affairs of the museum that by then bore his name.

New efforts to create a period room came about only in the early 1960s, after the Dittrick Museum regained its gallery and the Cleveland Medical Library Association created the staff position of museum curator. Filling this new post was Genevieve Miller, Ph.D., who had only recently completed editing the *Bibliography of the History of Medicine of the United States and Canada, 1939-1960*. Under Miller's guidance, the museum collections were re-installed in the large clerestoried gallery designed to house the fledgling historical museum of the Cleveland Medical Library Association, while the riches of the Surgeon General's Library found a new home in the recently built National Library of Medicine in Bethesda, Maryland. In a plan for museum development submitted to the Trustees of the Cleveland Medical Library Association in 1962, Miller made specific mention of two possible period room displays: an office of a Western Reserve physician, ca. 1850, and a Cleveland pharmacy, ca. 1880.<sup>11</sup>

By 1966 the Dittrick Museum exhibit program again included a doctor's office period setting. This time the office was not that of Abner Webb, however. A new persona, or more appropriately, personae, arrived on the scene: Adam Benjamin Denison. In February of 1964 the Dittrick Museum had received a donation of manuscripts, artifacts, diplomas and pictures belonging to five generations of physicians, each named either Adam Denison or Adam Benjamin Denison, spanning more than 150 years. This accession inspired the re-creation of the office of Adam Benjamin Denison, although it was never quite clear which generation the installation was intended to portray.<sup>12</sup> Because the Denison accession did not include much in the way of office furnishings, most of the accoutrements consisted of the belongings of other Western Reserve physicians. This was especially the case with regard to furniture. For example, two pieces of early Ohio furniture, a cherry desk and a walnut secretary, came from the practice of John B. Harmon





*Fig. 2. The "Adam Benjamin Denison office," Dittrick, Museum, 1966. Much more sparse than its 1943 precursor, the "Denison" office consisted of furniture and medical paraphernalia belonging to several Ohio physicians. Only a portrait, framed coat of arms (on door at center), carpet, and assorted smaller items actually came from the Denison family. Presence of the phrenology bust and steamer trunk are curious. Might these objects suggest that an itinerant phrenologist was paying a visit to the Drs. Denison?*

(1780-1856), while the ca. 1886 examining chair (which appeared earlier in the "office of Abner Webb") once belonged to Edward Cranch or his son Arthur Girard Cranch, homeopathic physicians of Erie, Pennsylvania and Lakewood, Ohio. Without challenging these embellishments to the "Denison" office, it is reasonable to question the purpose of including a phrenology bust as a part of the display (see Fig. 2). This and other anomalies and anachronisms discredited the overall authenticity of the "Denison" office and diffused its purported focus--the Denison physicians of the Western Reserve. The display was deemed popular, nonetheless, and for this reason it was transferred temporarily to the May Company store in the center of Cleveland in September, 1971. Following this venture into community outreach, the Denison office was returned to its original location in the Dittrick Museum.

Over the past fifteen years subtle, but significant changes have altered the character and appearance of the nineteenth-century doctor's office at the Dittrick Museum. Perhaps the most important change, which occurred more gradually than abruptly, was the staff decision to abandon the Denison family as a thematic focus. By the mid 1970s the Dittrick Museum room came to be presented as a "typical" doctor's office in 1880. The date, not the persona, became the organizing principle that guided furnishings and interpretation. With this in mind, Curator Patsy Gerstner made a careful reassessment of the room's contents. Gerstner and museum volunteer Faith Grotz identified and dated all the specifically medical artifacts in the room with the aid of instrument-makers' catalogues. All objects not appropriate to the target date of 1880 were removed and placed in museum storage. This weeding out of anachronistic items was prompted chiefly by Gerstner's decision to develop the museum's educational program. First she visited school classrooms to prepare students for a museum visit and then, back at the museum, used the 1880 doctor's office to show her visitors what it had been like to be sick in the 1880s and what a visit to the doctor might have been like at that time.<sup>13</sup> In this context, the historical accuracy of the period room was a matter of primary concern and Gerstner made considerable efforts to achieve it.

Although the interpretation and didactic function of the Dittrick Museum's 1880 doctor's office has not changed much in recent years, the installation itself has. During 1983 and 1984, the main interpretive gallery underwent a complete renovation. The completed exhibit hall, entitled "Medicine in the Western Reserve since 1800," features three period settings: a Cleveland pharmacy, ca. 1880, and two Western Reserve doctor's offices, dating from 1880 and 1930 respectively.<sup>14</sup> The decision to maintain these settings as part of the museum exhibit program was motivated by the conviction that they had proved their worth as a means to interact with small groups touring the museum. To enhance their

effectiveness in this regard, the staff concluded that the architectural aspects of the two doctor's offices--floor, walls, windows, etc.--could be made more authentic and that the selection of artifacts in each room needed to be substantiated more fully by research.

Research on the 1930s doctor's office did not take up too much of staff time since the office setting was a composite of two actual medical practices that became museum property in 1979 and 1980. In order to begin the task of determining just what belonged and what did not, the staff turned chiefly to photographic sources showing office interiors of the 1920s and 1930s. Especially helpful in this regard was the journal *Medical Economics*, which in October of 1927 began a photogravure section entitled "Practice-Building Offices." By February of the following year, examples of such offices were brought together in the "Better Equipment Album," which *Medical Economics* staff "distributed to a number of progressive surgical instrument houses throughout the country," where they could be consulted by interested physicians.<sup>15</sup> While unearthing a copy of this album proved futile, the illustrations in *Medical Economics* proved invaluable. The journal also published feature articles on office layout, choice of color, flooring, and so forth, for the general practitioner and specialist alike. (This series of articles stopped in 1931, perhaps reflecting the economic retrenchment forced on physicians by the Great Depression.)

With these contemporary sources in hand, the Dittrick staff began reconstructing the 1930 office with the confidence that it would look and "feel" authentic. Older museum visitors confirm the results daily, as they recall quite similar physicians' offices of their childhood (Fig. 3).

Reconstructing the 1880 office and re-installing its furnishings was a much more challenging task, particularly since photographs of doctors' offices proved to be far less abundant for this earlier period than might be suspected.<sup>16</sup> In lieu of photographic evidence, probate inventories were inspected in the hope that they might contain useful information. A systematic survey of Cuyahoga County Archives by museum volunteer Judy Chelnick brought to light several inventories of physicians' estates in the 1870s and 1880s. The most promising of these inventories was an 1873 listing of the household and office furnishings of Thomas Gold Cleveland, M.D. (1825-1873). The Dittrick's Western Reserve doctor's office thus became a "Cleveland" office, although it is not presented to the public as the office of Dr. Cleveland. In contrast to most others of the period, the Cleveland inventory contains an itemization of all furniture of his office, which was located in his residence. The list of Cleveland's office contents was matched with artifacts in the Dittrick Museum collections deemed appropriate with regard to function, style and date. Unfortunately, the Cleveland inventory





*Fig. 3. 1930s doctor's office, Dittrick Museum, 1984. Recreating a 1930 office at the Dittrick Museum consisted chiefly of combining appropriate elements, as confirmed by studying period photographs, from two medical practices that came to the Dittrick Museum in the late 1970s. Finding suitable architectural features, from the nine-inch linoleum tiles to the textured glass window sash, proved to be something of a scavenger hunt, but persistence yielded results (and angry confrontations with canines at Cleveland wrecking yards).*

did not include an itemization of the doctor's instruments or medical books, so the staff fell back upon Gerstner's prior research when it came to strictly medical and surgical furnishings.

For the general decor of the 1880 office, both the research and the actual reconstruction were greatly aided by students in Gerstner's museum studies class. These students, candidates for the masters' degree in history at Case Western Reserve University, undertook the task of researching floor treatment, wall finishes, window hangings, and so forth. William Seale's *Recreating the Historic House Interior*<sup>17</sup> constituted the basic guide for the students' work on the Dittrick Museum period room. This definitive work, plus research in local sources, enabled the class to draw up a series of specific recommendations for particular elements of room decor. Museum staff approved these recommendations and then supervised the students' actual work of carpentry, painting, papering, and all the other details that transformed the space into a room (Fig. 4).

### III

What of value can be gleaned from the Dittrick Museum experience with the medical period room? In no way do I wish to suggest that the Dittrick Museum period rooms are superlative examples of the genre, and therefore ought to be emulated, much less imitated. Far from it. There is still ample space for improvement, both in how the rooms are put together and in how they are presented to the museum visitor. It is the *process* of creating the rooms, not the product, that merits attention. From exploring the process of planning, researching, and installing the Dittrick Museum, I have gleaned the following insights:

1. *Remember that historical accuracy comes first, regardless of the intended function of the period room or setting.* This may sound like gratuitous advice, but it is worth reiterating for the simple reason that the public looks to museums as arbiters of historical "fact." Because museums collect real, tangible objects that our forebearers owned and used, the displays in which these objects are shown must live up to visitors' expectations of historical accuracy. In the case of the period room, individual objects acquire meaning and significance only in relation to each other and to their settings; it is the overall context that counts most. Any flaw, any anachronism, can serve to vitiate the effectiveness of the whole. Consequently, historical accuracy must not be sacrificed, even at the expense of more labor than had been anticipated in the original estimate.





*Fig. 4. 1880s doctor's office under construction, Dittrick Museum, 1983. The smiling visage of Collections Manager Lisa J. Schott conveys the excitement that all the Dittrick Museum staff felt as the 1880 office took shape. Building a proper period setting with "real" walls, window, door, floor, and so forth was plain hard work, but satisfaction with the results provided ample compensation for staff efforts. Once this shell was complete, Case Western Reserve University museum studies students began the task of decoration, which included wall papering, painting, and even floor stencilling.*



*Fig. 5 (above) and Fig. 6 (facing). 1880s doctor's office, Dittrick Museum, 1988. These two views show the 1880 office in its present state. As seen in Fig. 5, the room is open on one side and it is here, on a barrier railing, that a label explains the character of the room to the visitor. Tours by museum staff often include discussion of particular objects, relating them to the state of medical knowledge and practice at the time of the target date, ca. 1880. For example, the presence of a microscope (justified by its inclusion in an 1873 inventory of a Cleveland doctor's office) permits a discussion of the rise of bacteriology in the 1880s and the increasing importance of the laboratory in medicine. The skeleton (Fig. 6) in the closet prompts many questions. Answers often involve exploring how people studied to become physicians in the nineteenth century, from preceptor training to university affiliated medical department. Usually the room has a feel of lived in clutter, if only because it is used frequently for such didactic purposes.*



2. *Compose a succinct statement of purpose.* This statement indicates whether the exhibit is an actual restored room or a hypothetical reconstruction. It also establishes the character of the office. For example, is the exhibit to show a specific individual's office or to represent a composite office illustrating the general state of medicine at a given point of time? If the office is meant to be that of a particular physician (real or imaginary), the identity of the represented individual needs to be clarified. Was that person an orthodox practitioner or a sectarian one, a generalist or a specialist, urban or rural? Further specificity comes by establishing the temporal and thematic context of the office. Does it document a single moment in time or cover a broad span of years? Does it portray a particular medical event, a surgical procedure or an endoscopic examination, for example? Taken together, the decisions made in each instance help refine and clarify the statement of purpose. This statement then serves to guide both the in-house approach to the period room and the interpretation of the exhibit to the museum visitor.

3. *Prepare a written furnishing plan.* The furnishing plan is not simply a list of artifacts already on hand that might be appropriate for the room setting. Instead, this document should outline the *ideal* room contents and their placement, as substantiated by research in primary and secondary sources. Preparation of a furnishing plan can begin with a review of the medical knowledge and practices that prevailed at the time of the room's stated date. This review is followed by an analysis of the structure of medical practice, with particular attention given to the degree of specialization (and hence the nature of the doctor's armamentarium), the predominant forms of illness and trauma peculiar to the physician's patients, and so forth. These elements further narrow the definition of what kind of practice the doctor pursued on a daily basis, and thus suggest what kind of detailed considerations come into play when composing the list of furnishings. With a furnishing plan, there is less inclination to make use of artifacts simply because they are available. The plan constitutes a wish list to be filled as occasion permits by purchase, exchange or solicited donations.

4. *Seek outside expertise if needed, particularly for assistance with architectural details and the decorative arts.* Medical museum staffs are small, generally speaking, and real competence usually is restricted to their institutions' subject matter and collections. Rather than take on architectural and art history as well, it seems more advisable to seek help from persons with special knowledge in these fields. This suggestion does not necessarily mean engaging a professional consultant; staff from nearby history or art museums are often willing to lend a hand.



They usually can review furnishing plans and make specific recommendations about non-medical features, from choice of floor covering to period lighting devices. At the Dittrick Museum, discussions with the Curator of Collections of the Western Reserve Historical Society led to the permanent loan of a ca. 1875 fireplace mantelpiece. This acquisition, in turn, provided the keynote for other decorative elements in the room (window framing, crown moulding, and chair rail).

5. *Make it a point to visit first rate museums, medical and non-medical alike, that have period room displays.* Connoisseurship in any domain, be it fine wines or medical period rooms, depends upon the breadth of individual experience. To acquire such experience there is no substitute for travel. Unfortunately, armchair travel, by way of exhibit catalogues or museum brochures, just is not the same. The objects need to be viewed firsthand in their respective settings so as to gain a sense of scale, design and workmanship. Examining room installations with a critical eye gives a feeling for what works and what does not. It is guaranteed that you will return home brimming with new ideas and insights that can be adapted effectively to your institution's particular circumstances.

## NOTES

1. Medical period rooms almost never include hospital rooms, surgical suites, or outpatient dispensaries, which by the turn of this century were commonplace.

2. See John Harley Warner, *The Therapeutic Perspective: Medical Practice, Knowledge, and Identity in America, 1820-1885* (Cambridge: Harvard University Press, 1986).

3. See especially George Rosen, *The Specialization of Medicine, with Particular Reference to Ophthalmology*, 2nd ed. (New York: Arno Press, 1972) and *The Structure of American Medical Practice, 1875-1941* (Philadelphia: University of Pennsylvania Press, 1983).

4. Edward P. Alexander, "Artistic and Historical Period Rooms," *Curator* 7(1964):263-81; and A. E. Parr, "Habitat Groups and Period Rooms," *Curator* 6(1963):325-36. Interest in the period room has not waned in more recent time, but those in different subdisciplines may disagree over its usefulness. Historians of technology have generally espoused the period room, using the terms habitat, environmental, or systems exhibit to identify the genre. See especially George Basalla, "Museums and Technological Utopianism," *Curator* 17(1974):105-18,



and Theodore Z. Penn, "Exhibit Review: Slater Mill Historic Site," *Technology and Culture* 21(1980):56-66. Decorative arts historians, in contrast, seem disenchanted with the period room. While willing to keep those that now exist, they would not use the room as the ideal vehicle for presenting decorative arts objects to their best advantage. See discussions by several leading curators and educators in the decorative arts field in Elaine Greene, ed., "The Period Room Reconsidered: A House & Garden Symposium," *House & Garden* 158(October 1986):218-24, 256-65.

5. E. McClung Fleming, "The Period Room as a Curatorial Publication," *Museum News* 50(June 1972:39-43).

6. Personal communication from Mary Ann Landis, dated December 15, 1987.

7. Dittrick's fascination with the Webb materials had already resulted in a published biographical sketch in 1941. See "A Medical Pioneer of Trumbull County a Century Ago," *Ohio State Medical Journal* 37(1941):355-59, 459-63.

8. See "One Hundred Years of Medicine," *Museum News... Cleveland Health Museum* 4(October 1943.)

9. "Museum Corner," *Bulletin of the Academy of Medicine of Cleveland* 28(December 1943):13.

10. See, for example, "The Equipment, Instruments, and Drugs of Pioneer Physicians of Ohio," *Ohio State Archeological and Historical Quarterly* 48(1939):198-210, and "Urinalysis, Instruments of Precision, the Stethoscope, et cetera, of the Period, 1835-58," *Ohio Archeological and Historical Quarterly* 49(1940):347-60.

11. See Genevieve Miller, "The Howard Dittrick Museum of Historical Medicine," typescript copy, 10 pp., Archives, Cleveland Medical Library Association. Miller presented this plan to a receptive audience at the Seminar for Historical Administrators at Williamsburg, Virginia, on July 24, 1962.

12. See Barbara Cooper Smith, "Doctor's Office," *Bulletin of the Academy of Medicine of Cleveland* 51,2(February 1966):10-11.

13. See Patsy A. Gerstner, "Medical History for Young People: Experience at the Howard Dittrick Museum of Historical Medicine," *Clio Medica* 10(1975):161-65.

14. James M. Edmonson, "Changes in the Dittrick Museum," *Bulletin of the Cleveland Medical Library* 30(Spring/Summer 1984):23-25.

15. See the especially fine pictorial entitled "Practice-Building Offices," in *Medical Economics* 4 (January, 1928). While the series itself is unpaginated, a brief description can be found on pp. 34-35 of this particular issue.

16. This observation was confirmed by conversations with Stanley B. Burns, M.D., pre-eminent collector of historic medical photographs, and by consulting Rima D. Apple, comp., *Illustrated Catalogue of the Slide Archive of Historical Medical Photographs at Stony Brook* (Westport, Conn.: Greenwood Press, 1984).

17. See William Seale, *Recreating the Historic House Interior* ( Nashville, Tenn.: American Association for State and Local History, 1979).

## AUTHOR

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As a Fellow (1974-78) in the Hagley Graduate program, Edmonson studied the history of technology, leading to the M.A. (1976) and Ph.D. (1981). In 1978 and 1979 he conducted archival research in Paris as a Fulbright-Hays Fellow. In 1981 his completed dissertation received the Wilbur Owen Sypherd Prize for the outstanding doctoral dissertation in the humanities at the University of Delaware. It has recently appeared in monograph form as *From mecanicien to ingenieur: Technical Education and the Machine Building Industry in Nineteenth-Century France* (Garland Publishing, 1986)

In addition to his responsibilities as Curator of the Dittrick Museum, Edmonson is Assistant Professor in the History Department of Case Western Reserve University. In this capacity he teaches the history of medicine and medical technology in the Program in the History of Technology and Science and in the School of Medicine.

## *An Alternative Perspective: The Medical Period Room*

*by J. T. H. Connor*

In his article on the medical period room, Dr. James Edmonson reviews the changing attitudes to this exhibit form and discusses the evolution of the historical period room at the Howard Dittrick Museum in Cleveland. Dr. Edmonson's discussion of this topic is original, probing and welcome. Indeed, it should become required reading for all medical museologists who are responsible for or who are considering the development of a medical period room. In responding to this article, therefore, I wish to offer less a critique of it (for I agree with its general thrust), than to suggest some alternative thoughts on the topic at hand.

While several points of interest and importance are raised in Dr. Edmonson's paper, two general related issues seem to predominate. First is the question of historical accuracy in the preparation and presentation of the medical period room. On one hand, I am in entire agreement with the implicit criticism that a great many of the existing medical period rooms demonstrate historical inaccuracies. Certainly, there can be no argument about the curatorial impropriety of placing inappropriate artifacts in an historical setting specifically identified as the "office" of a named physician (as Edmonson relates occurred with the Dittrick's first period room). However, since curators rarely are fortunate enough to acquire the complete documentary and possessions of individual physicians--let alone five in the case of the Denisons--or the complete physical structure, including its medical contents,<sup>1</sup> some artifact augmentation may be deemed appropriate, if not necessary.

This last comment perhaps begs the question implicit in Edmonson's criticism. Why does the desire exist to add material to an exhibit when such action is liable to leave one vulnerable to a charge of "consciously disseminating misinformation"? In all likelihood, part of the answer lies in the "exhibitionist" character of museum personnel. Presumably the reason that many people choose museology as a career is a belief in the educational merit of displaying the

material culture of a particular period, discipline or culture. Thus, the orientation or emphasis of many museum personnel is more toward visual presentation than controlled historical accuracy. If this argument is valid, then does it in any way undermine Edmonson's criticism? Of course not. Historical inaccuracy will always remain such, regardless of one's career motives. What I am suggesting, however, is that historical inaccuracy may not be such a curatorial crime if the exhibit, in and of itself, works. For example, for all the discrepancies associated with Dittrick's first medical period room, the exhibit was a "rave success" with high levels of public interest and attendance. Presumably, then, those visitors left this exhibit knowing more about nineteenth-century medicine than they did previously--arguably one of the main purposes for mounting any exhibit.

To be sure, there can be no denying the artificiality of Howard Dittrick's creation, but that is a risk any curator should be prepared to assume when undertaking a project such as a period room in an ahistorical or artificial environment such as a large exhibit gallery, hall or department store. I am not advocating that exhibits should be free flights of fancy and completely devoid of historical accuracy (such curatorial anarchy would be totally unacceptable), but merely asserting that there is an element of "showbiz" in the creation of generic medical period rooms which often has its price. Moreover, if a medical period room is of the generic variety (as compared with that identified with a specific physician,<sup>2</sup> locale,<sup>3</sup> or function<sup>4</sup>), presumably interpretative material available to visitors would explain that the exhibit is a "creation" rather than "re-creation" or even "facsimile" of a *real* nineteenth-century physician's office. Likewise, owing to the usually contrived setting of most medical period rooms, the majority of visitors probably realize that they are viewing a historical simile rather than a historical *metaphor*, and thus may appreciate that there is not complete historical verisimilitude.

In sum, then, while the pursuit of historical accuracy should always be a goal for any curator, the constraints and aims of the formal exhibit medium perhaps dictate that other imperatives may detract from the full achievement of that goal.

The second major theme of Edmonson's discussion centers on the concern that "recreated doctors' offices present a static, unchanging ideal of medical practice." Again, the truth of this statement is evident to those who have visited medical period rooms. By the same token, though, is not the "static" nature of a period room very much the *raison d'être* of this exhibit form? The period room in effect freezes a moment in time, as in a photograph, depicting an event or theme which then can be examined by visitors more or less at their leisure. Furthermore, if visitors are able to walk through the period room rather than merely viewing it



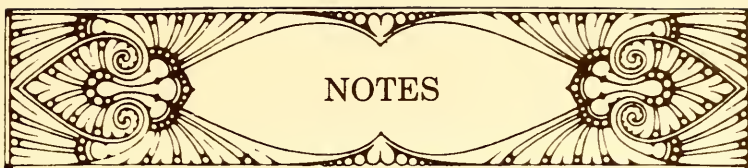
from a distance, a sense of "time travel" can be created--the visitor is not merely a spectator of, but rather a participant in the exhibit.

The related point that the medical period room often conveys the idea that medical practice is static also has validity. Again, however, if the appropriate accompanying interpretative material explains that the room spans a particular era (typically late nineteenth century through the early twentieth century), then the evolutionary nature of medical practice can be portrayed in a relatively effective manner. For example, as it was not uncommon for practitioners to practice upwards of fifty years in their profession, it would not be inappropriate to display medical artifacts spanning, say, the years 1875 to 1925. Thus, the evolution of surgical instruments from the pre-antiseptic to the aseptic period could be characterized conveniently. Similarly, the juxtaposition of like apparatus of different vintages in physicians' offices perhaps was not unusual since these doctors replaced equipment, without necessarily discarding their former apparatus. Hence, it is possible to convey a sense of development within an otherwise static exhibit.

Whatever other problems this latter approach may give rise to, two come to mind. The first is the risk of creating certain historical anachronisms. While the presentation, for example, of a 1940s portable ECG unit in a turn-of-the-century office clearly would be wrong, other apparent anachronisms might be acceptable. For instance, the practice of bloodletting is generally believed to have become outmoded by the late nineteenth century, yet North American surgical instrument catalogues of the 1920s continued to list scarificators and cupping sets for sale, suggesting that a market for them still existed.<sup>5</sup> Hence, as incongruent as it might seem, apparatus of such diverse natures as bloodletting instruments and a Dare haemaglobinometer might have once cohabited the same office space. The second problem is audience misinterpretation or confusion due to the close proximity of similar instruments of different ages. Again, the answer to this criticism lies in appropriate interpretative material where the premise of the exhibit and an adequate explanation of its structure are conveyed to visitors.

Ultimately, what is the nature of this response to Edmonson's discussion of the medical period room? As stated at the outset, I agree with the general approach and intent of the article and further agree with the criticisms raised. (As a result of having read Dr. Edmonson's essay, I am seriously rethinking the function and interpretation of my own Victorian doctor's office.) Thus, the thrust of this response is not critical, but rather an attempt to offer an alternative viewpoint on the rationale and implementation of the medical period room, with the hope that it might promote discussion within the medical museological society.





## NOTES

1. Barnes Riznik writes that in Plainfield, Massachusetts is a "striking three-dimensional document of New England history." Referring to the house of Dr. Samuel Shaw, built in 1833, and preserved by his descendants, Riznick describes it as follows:

Extra rooms on the east end, especially a corner medicine room and separate large doorway, were included for the doctor in the original design, a local builder's adaptation of a large, two-story [sic] farmhouse, typical of many raised in the late eighteenth and early nineteenth century throughout Massachusetts. It is said that Dr. Shaw also used a small room behind the office as a bedroom which he could enter, coming home late, without disturbing the sleep of the household. The chairs in the medicine room are Windsor-style and painted black. There are three bookcases, a desk, a table, and a large medicine cabinet which includes 16 small and eight large drawers. Upper shelves in the cabinet still contain free-blown glass jars with brass lids and tin lids, glass-stoppered bottles, and vials filled with medicines. Among Shaw's medical equipment are brass scales, pocket scales, a large bronze mortar and pestle, marble pill slab and roller, obstetrical forceps, tooth extractors, surgical instruments, and syringes. (pp. 10-11)

See Riznick, "The Professional Lives of Early Nineteenth Century New England Doctors," *Journal of the History of Medicine and Allied Sciences* 19(1964):1-16.

2. See, for example, Susan Nimocks and George W. Grider, "McDowell House, Apothecary and Gardens," *Caduceus: A Museum Quarterly for the Health Sciences* 3(Spring 1987):44-53; and Jean Murray Cole, "Hutchison House," *Canadian Collector* 13(September-October 1978):23-27.

3. For example, there is the recently opened "Doctor's Surgery" at Blists Hill Open Air Museum in Ironbridge, England. This site is described as "typical of the many one-man 'working-class' practices which could be found in the industrial conurbations and mining areas of Britain." See "Blists Hill Open Air Museum," *Medical History* 31(1987):224.

4. Edmonson refers to a mining company doctor's office project currently under way at Eckley Miners' Village in Pennsylvania.

5. *Illustrated Catalogue of Standard Surgical Instruments and Allied Lines*, 4th ed. (Toronto: J.F. Hartz Co. Ltd., n.d. [Ca. 1920s]), p. 57.

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